HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

November 6, 2013

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

REVIEWING THE BASIC HEALTH PLAN PROPOSED RULE

This week, our *In Focus* section comes to us from HMA's Tom Dehner and Chad Perman as they review the Department of Health and Human Services (HHS) proposed rule on Basic Health Plans (BHPs). The BHP is a state coverage option authorized under the Affordable Care Act (ACA) for individuals who do not qualify for Medicaid and whose income does not exceed 200 percent of the federal poverty level (FPL).

Basic Health Plan Summary

In early 2013, HHS decided to delay implementation of the BHP option for states until January 2015. In September 2013, HHS issued a proposed rule governing the BHP. The rule sets basic program parameters and establishes processes through which states seek approval of their BHP plan (a BHP Blueprint). The rule also outlines how and when states will get information about the financial terms of the BHP, which are premised on states receiving 95 percent of the amount that eligible enrollees would have received in public subsidies, both advance premium tax credits (APTC) and cost-sharing reduction (CSR), had they enrolled in a Qualified Health Plan (QHP) on the Exchange. Comments on the rule are due by November 25, 2013.

Generally the rule is designed to build directly upon existing regulations that govern Exchanges. The BHP offers coverage in lieu of subsidized coverage through a state's Exchange, so many eligibility rules and processes are equally applicable to the BHP. In addition the rule adopts the concepts and features that govern the insurance affordability programs in the ACA, including streamlined eligibility and enrollment, minimum benefit coverage, maximum cost sharing and others. In some circumstances, the regulation proposes adopting Medicaid rules or offers states the option to apply either Exchange or Medicaid rules.

The rule authorizes any state to have a BHP, no matter its decision on operating an Exchange or expanding Medicaid. However, it is less likely that a state that has deferred either provision of the ACA will opt for a BHP as the program is designed to work in conjunction with a state featuring both. The emphasis of the rule and purpose of the BHP option is to simultaneously authorize greater state flexibility to provide coverage that is integrated with existing state coverage programs. The relationship of the BHP to other subsidized coverage under the ACA is depicted conceptually in the table below.

	Medicaid Expansion eligibility group	Basic Health Program (BHP)	Exchange subsidies
Percent of Federal Poverty Level (FPL)	0-138%	138-200%	200-400%

BHP Timeline

Date	Milestone
September 2013	Proposed Rule Released
Fall 2013	Preliminary Federal Payment Notice for Calendar Year 2015
TBD	Blueprint Submission
TBD	Competitive Contracting Process
TBD	Blueprint Approval
January 1, 2015	BHP Start Date

Key Basic Health Plan Provisions

Basic Health Program Blueprint

States interested in establishing a BHP will first submit a BHP blueprint for approval by the Secretary of the Department of HHS. Using a process modeled on the Exchange blueprint, HHS will certify state BHPs and grant operational authority.

States must propose a funding plan and sources besides the BHP trust fund to cover annual expenditures. HHS will also analyze the BHP blueprint for compliance. Blueprints will be posted on-line for HHS review and do not need to be final when uploaded.

General Requirements

The state must ensure that the BHP is available statewide and available to all individuals who qualify. A cap on enrollment is not allowed. A state implementing a BHP may not offer premium tax credits through an Exchange to individuals within this income category.

A state establishing a BHP must be able to perform core operating functions. These include: a) eligibility determinations using the single streamlined application; b) processing appeals; c) contracting with standard health plans; d) conducting oversight and financial integrity auditing; e) providing consumer assistance; f) extending statutory protections to American Indians and Alaska Natives; g) ensuring civil rights protections; h) data reporting for program oversight.

States must require health plans to provide clear information on premiums, services, scope and duration of services, and applicable cost-sharing. In addition, states must require that health plans offering BHP coverage make available provider lists to consumers.

HHS will audit state BHP operations annually, if not more often, to ensure compliance with federal statutes and the state's BHP Blueprint.

Eligibility and Enrollment

The rule proposes that a BHP's eligibility and enrollment policies and processes should align with the state's other insurance affordability programs. Eligibility standards are set by the ACA and there is no flexibility for states to alter eligibility criteria. States may not restrict eligibility by geographic location and may not cap enrollment. BHP eligibility is limited to those who:

- are a resident of the state and a U.S. citizen or lawfully present non-citizen;
- not eligible for State Medicaid coverage or Medicare; and
- have household income between 133 and 200 percent FPL (or, lawfully present non-citizens ineligible for Medicaid income between 0 and 200 percent FPL)

Either the BHP or another state governmental entity that determines Medicaid or Exchange eligibility should perform the eligibility determination function, using either Medicaid or Exchange standards. The rule proposes that BHPs use the single, streamlined application that is required by the ACA for Medicaid and Exchange coverage. As a practical matter, very close coordination with other Insurance Affordability Programs will be a necessity.

Benefits & Cost-sharing

The benefit package that is offered as coverage to enrollees in the BHP is a Standard Health Plan (SHP). Benefits offered must include the ten essential health benefits. If the SHP is offered by a health insurance issuer, it is subject to a medical loss ratio requirement of 85 percent. A state may decide to offer coverage that is more generous than the state's EHB benchmark plan, but otherwise all the existing EHB requirements applicable to Exchange plans (and certain other insurance plans) are applicable.

Benefit designs will be flexible depending on a state's needs. The rule proposes adopting the approach used in relation to the Medicaid expansion to allow states to offer more than one SHP. States can establish multiple Medicaid benchmark plans that serve distinct populations, if each meets baseline EHB standards.

The rule adopts all Exchange cost-sharing requirements with the overall intent of ensuring that cost-sharing is not higher than it would be for similarly situated individuals receiving exchange-based subsidies. Monthly premiums cannot exceed what an individual would have to pay, taking into account tax credits, for the applicable benchmark plan (the second lowest-cost Silver plan). The rule also incorporates existing cost-sharing rules and prohibits cost-sharing on defined preventative services.

Competitive Contracting Process

The selected issuer(s) of the plan is called the Standard Health Plan Offeror. The SHP Offeror will be selected using a competitive procurement process, which could be a joint procurement for BHP and other programs, i.e., Medicaid. Eligible offerors include HMOs, health insurance issuers, networks of health care providers, and existing Medicaid/CHIP HMOs (licensed or not). The rule proposes that at least two SHP offerors must be available to consumers. This provision of the proposed rule expands upon the legislative requirement, which says that states "shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individual."

The rule also authorizes states not to use a competitive process to select SHP Offerors in the first year of the program. This provision would allow states to utilize existing Medicaid managed care organizations to serve as SHP Offerors in 2015.

Program Financing

The ACA requires that HHS pay states a per enrollee amount based on 95 percent of the amount that would have been provided as a premium tax credit and cost-sharing reduction if the enrollee were enrolled in a QHP on the Exchange.

HHS will publish a payment methodology that states can use to determine per enrollee BHP payments. For the initial year of operation (beginning January 2015), the payment notice will be published alongside the final version of this rule. Payment rates will be per-enrollee and are necessarily state-specific, because premium tax credit amounts will vary by state. States will receive an aggregate payment amount by multiplying the payment rate by projected enrollment. This amount will not be adjusted retrospectively except to account for actual enrollment instead of projected enrollment.

The rule discusses the applicability of risk mitigation to the BHP in detail. In effect, reinsurance payments and risk corridors will not be available for standard health plans and will not be considered in setting BHP funding amounts. HHS will set a risk adjustment factor to be used in the BHP funding methodology. As a result the BHP will not be a part of the individual market risk pool in states operating a BHP. This risk adjustment model, unlike the individual market model, will be prospective, in order to improve predictability in federal funding for states. Greater detail on risk adjustment will be published with the payment notice.

HMA Medicaid Roundup

Alabama

HMA Roundup

Alabama Policy Cancellations Spark Controversies. Kaiser Health News reports that with the enrollment period now open for health plans offered on exchanges, many individual plan holders have been unpleasantly surprised by the jump in monthly rates. This article highlights the experience of thousands of BlueCross BlueShield of Alabama policy holders who have received letters about the cancellation of their health plans. Some of the profiled individuals, who do not qualify for subsidies, will pay significantly higher premiums and higher deductibles. BCBS of Alabama attributes the increase to the Affordable Care Act, which features guaranteed issue and minimum essential health benefits. Furthermore, with an unusually high level of chronically ill residents, Alabama's individual policy holders will experience faster premium growth than in other states to spread the costs of those sicker newly insured. However, critics note that, in Alabama, BCBS has little competition and little incentive to lower prices. Advocates criticized Gov. Robert Bentley for rejecting the Medicaid expansion and refusing to enforce the ACA's provisions. Read more.

Arkansas

HMA Roundup

Arkansas Holds Hearings on Exchange Enrollment, Cancellations, and Exchange Budgeting. On October 30, 2013, insurance industry executives spoke before a state legislative panel about their experience with the Arkansas Health Insurance Marketplace. Among the three plans (Arkansas Blue Cross Blue Shield, QualChoice, and Arkansas Health & Wellness Solutions) represented before the legislative oversight committee, fewer than 170 Arkansans had enrolled in their plans on the state's health exchange. National Blue Cross Blue Shield figures were not available. QualChoice CEO Michael Stock expressed concerns that the website glitches at Healthcare.gov would deter the young and healthy from enrolling, which would skew the cost experience from actuarial models. State Insurance officials have given the plans flexibility to avoid issuing cancellation letters to policy holders through December 31, 2014. Deputy Insurance Commissioner Cynthia Crone commented that the state could maintain its exchange site for under $400,000 annually, down from a prior estimate of $500,000. Read more.

California

HMA Roundup

Alameda Alliance Removed from Health Exchange. On November 1, 2013, Alameda Alliance for Health was removed from Covered California—the state's health exchange—for failing to obtain a commercial insurance license by an October 31, 2013 deadline. The plan's $8.4 million in net equity was insufficient to meet the state's solvency threshold of $19.2 million. As a result, Alameda Alliance and its Medi-Cal managed care plan have been placed under tighter financial monitoring. According to the LA Times, Alameda has expressed its plans to meet the financial solvency requirements in time to obtain a license by December 2013. Covered California executive director Peter Lee expressed optimism that Alameda could rejoin the exchange in the future. The loss of the plan leaves Alameda county with three choices on the exchange: Anthem Blue Cross, Blue Shield of California and Kaiser Permanente. Read more.

Department of Insurance Requires Blue Shield to Delay Policy Cancellations. On November 4, 2013, the California Department of Insurance required Blue Shield of California to put off—by three months—the cancellation of 80,000 health insurance policies covering some 113,000 people. These individual health plans do not meet ACA requirements for minimum coverage benefits. Blue Shield officials have expressed concerns that the three month extension in non-grandfathered individual policies could result in individuals being subjected to two deductibles and the loss of subsidies that would otherwise have been available on the exchange. Read more.

Medi-Cal Managed Care Available in All 58 Counties in California. As of November 1, 2013, Medi-Cal managed care became available in all 58 California counties, including 20 rural counties that had previously not participated. Toby Douglas, director of the Department of Health Care Services, estimates that the Medi-Cal managed care expansion will bring some 274,000 residents into the managed care fold. Read more.

eHealth Enlists Legislative Supporters to Urge Covered California to Include Online Brokers. This past week, eHealth—a publicly traded online health insurance broker—convinced a variety of legislators to push Covered California to include online brokers on the state's health exchange. Assembly Health Committee Chair Richard Pan was joined by Sen. Ricardo Lara, and Assembly members Kevin Mullin, V. Manuel Perez, and Richard Gordon in letters urging the exchange to partner with "web-based brokers". eHealth CEO Gary Lauer had been unclear why the exchange had been so reluctant to work with online brokers, particularly given the established systems and infrastructure they had already developed. The exchange claims it needs to develop a custom interface for its own site and hopes to include online brokers by 2015. Read more.

Colorado

HMA Roundup—Joan Henneberry

Connect for Health Colorado board members remain dissatisfied with the pace of enrollment on the Exchange. At the board meeting on November 4, 2013, board members criticized the current process of first screening for Medicaid eligibility before individuals can complete an application for tax subsidies on the Exchange. The original plan for the state Medicaid agency and the Exchange to share a rules

engine including MAGI rules was scrapped in February 2013, when the Medicaid agency abandoned plans to jointly develop an eligibility product with the Exchange. As a result, Connect for Health Colorado is seeking an alternative in time for open enrollment to comply with Medicaid eligibility screening requirements. The Medicaid agency has since developed an application that screens both for MAGI and for the possibility of Medicaid eligibility under the old rules, bogging down the tax credit eligibility process with Medicaid-specific income and asset information. Board members have directed staff to find a fix and solution quickly. Connect for Health is expected to release new enrollment numbers on November 11. Read more.

Connecticut

HMA Roundup

Access Health CT Takes Bids to Confirm Customer Identities to Bypass Federal Glitches. This week, Access Health CT is taking bids from outside contractors to confirm customer identities, in order to bypass a root cause of the federal system's glitches. Access Health CT has taken other efforts to develop contingency plans that free the state's Exchange from being held captive by problems at the federal level. Access Health CT has successfully reduced the number of necessary federal "hub" functions from 14 to seven due to workarounds at the state's Exchange. Read more.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Proposed MMA Implementation Schedule Submitted to CMS. On October 30, 2013, the Florida Agency for Health Care Administration submitted the following proposed implementation schedule to CMS for approval. Following additional award announcements on October 31, 2013 for Wellcare in Region 4 and South Florida Community Care Network (SFCCN) in Region 10, there now remains only one outstanding protest from Care Access in Region 11.

MMA Draft Implementation Schedule FY 2014-15		
Regions	**Enrollment Date**	**Projected Enrollment**
2, 3 and 4	May 1, 2014	Region 2 - 118,181 Region 3 - 260,346 Region 4 - 302,581 Total = 681,108
5, 6 and 8	June 1, 2014	Region 5 - 189,529 Region 6 - 413,256 Region 8 - 208,587 Total = 811,372
10 and 11	July 1, 2014	Region 10 - 253,299 Region 11 - 575,187 Total = 828,486
1, 7 and 9	August 1, 2014	Region 1 - 103,383 Region 7 - 388,517 Region 9 - 258,305 Total = 750205
		Total ALL - 3,071,171

Source: Agency for Health Care Administration, Draft MMA Implementation Plan, October 30, 2013

Telemedicine Bill Aims to Lower Costs and Improve Access. Last month, Rep. Mia Jones filed House Bill 167, which would prohibit health plans or Medicaid from mandating face-to-face contact between health care provider & patient to qualify for reimbursement. The bill further authorizes the Department of Health to repeal rules that ban telemedicine services. Finally, the bill requires the Department of Health to study options to implement telemedicine for certain services, in such areas as stroke diagnosis, high-risk pregnancies, premature births, mental health and emergency services. Telemedicine enables patients with chronic diseases such as diabetes to interact with remote clinicians, exchange data, and can assist a patient during a video conference visit. Read more.

Miami-Dade Approves $830 Million for Jackson Health System. On November 5, 2013, the Miami Herald featured a story on a successful referendum in Miami-Dade County that raised property taxes to fund $830 million in upgrades for Jackson Health System. The decision offers a more secure financial future for the public hospital system to overhaul its finances and upgrade the hospital system's infrastructure and capital equipment. Hospital officials hope to invest $477 million in new construction projects, including a rehabilitation hospital and a dozen urgent care centers throughout the county. Some $350 million is earmarked for equipment upgrades, including diagnostic equipment, electronic medical records systems, and other hardware and software. Read more.

1.6 Million Floridians to Qualify for Subidized Health Premiums. According to a recent Kaiser Family Foundation study, nearly 1.6 million Floridians would qualify for subsidized health insurance premiums in 2014 for plans in the state's health exchange. The November 5 report estimates that Texas, California, and Florida would together account for 5.5 million citizens and residents who would qualify for subsidized health premiums, fully a third of the national total. In Florida, tax credits will not be available to those with incomes below the federal poverty level. Read more.

Baptist Health, Flagler Hospital, and Southeast Georgia Health System Explore Partnership Options. In a November 4, 2013 story, the Florida Times-Union covers efforts by Jacksonville's Baptist Health, St. Augustine's Flagler Hospital and the Southeast Georgia Health System to explore ways to collaborate. All three boards have approved the plan to identify "meaningful and substantive" partnering options, without sacrificing autonomy or independence. One clear area of joint-effort would be purchasing an IT system whose cost could be spread among the three hospital systems. Read more.

Georgia

HMA Roundup – Mark Trail

Georgia Provider Associations Support Medicaid Expansion. On October 31, 2013, the Atlanta Journal Constitution published an article highlighting the support of the both the Georgia Hospital Association and the Medical Association of Georgia for Medicaid expansion in the state. Gov. Nathan Deal has opposed expansion given that the state cannot afford the additional $4 billion over ten years to fund its portion of expanded coverage. Consumer advocates hope that the state would ultimately bend to pressure from the medical community to accept the additional federal funds (perhaps as much as $30 billion over ten years), as happened in other "Red States", such as Arizona and Arkansas. Read more.

Georgia Should Be the Seventh Largest Beneficiary of Health Exchange Premium Subsidies. In a November 5, 2013 story, Georgia Health News cites a recent Kaiser Family Foundation study that 17 million Americans would qualify for health exchange premium subsidies in 2014. Georgia is projected to have 654,000 residents who qualify for subsidies, seventh highest in the nation, just behind Pennsylvania and North Carolina. However, State Insurance Commissioner Ralph Hudgens offered a contrasting statistic: some 400,000 Georgians would face cancellation of their individual health policies because they do not conform with all ACA requirements. Read more.

Indiana

HMA Roundup—Cathy Rudd

High Risk Insurance Pool Extended by One Month. Due to ongoing difficulties in signing up for health plans using the Federally facilitated Exchange, Indiana Gov. Mike Pence decided on October 31, 2013 to extend the state's high-risk insurance pool by a month to January 31, 2014. The additional $6.3 million in state spending for this extension allows 6,800 Hoosiers to stay in the same plan until they are able to enroll in a plan available on the exchange. This 31-year old high risk pool has allowed individuals—who would otherwise be denied coverage due to pre-existing conditions—to have health insurance, albeit at significantly higher premiums that would be available on the Exchange. Read more.

Iowa

HMA Roundup

Optum Saved $86 Million for the State of Iowa. On November 4, 2013, Gov. Terry Branstad said that Optum's efforts to root out fraud and waste from Iowa's Medicaid program has saved the state more than $86 million over the last three years, or six times the value of the contract. The figure is about $18.5 million higher than the savings target for program integrity. Pre-emptive cost avoidance measures have limited the need for less effective "pay and chase" measures. Read more.

Louisiana

HMA Roundup

Despite $50 Million Budget Gap This Year, DHH Does Not Expect Cuts. In a financial update to the Louisiana state legislature's joint budget committee, the Department of Health and Hospitals (DHH) outlined a current fiscal year $50 million budget deficit in the Medicaid program, which requires legislative action to close. DHH Undersecretary Jerry Phillips does not expect cuts in Medicaid services or reimbursements. Rather, DHH will request $19 million in additional state funds to draw federal matching funds to close the gap. Phillips characterized this year's fiscal performance as an improvement over prior years, but acknowledged two key unexpected factors that affected the budget: a federal court order requiring Medicaid coverage of certain therapy services ($30.7 million) and a tax on health insurers participating in state Medicaid programs ($19.7 million). A separate $104 million pharmacy program shortfall is expected to be addressed with drug rebate dollars that need legislative approval. Read more.

Massachusetts

HMA Roundup—Rob Buchanan

Regulators to End Enforcement of Section 125 Plan Mandate. According to an October 31, 2013 Business Insurance article, Massachusetts regulators do not plan to enforce a six-year old rule that had previously required employers to offer non-benefit eligible employees access to Section 125 plans. These plans would be purchased by employees with pre-tax dollars in the state's health Exchange. However, recent federal guidance from the Department of Labor and IRS have clarified that the ACA bans the practice of offering Section 125 plans. The Connector Authority will allow employers to use 125 plans for eligible employees until they expire in 2014. Read more.

Michigan

HMA Roundup

Michigan Duals Awards Announced. Michigan is working with the Centers for Medicare & Medicaid Services (CMS) to implement an integrated delivery system of health care for persons dually eligible for Medicare and Medicaid (duals). Under the proposed model the state and CMS will enter into three-party contracts with Integrated Care Organizations (ICOs) to provide both acute and long term health care. The state will separately contract with Prepaid Inpatient Health Plans (PIHPs) to deliver behavioral health and developmental disabilities services to the demonstration population.

A three-year demonstration is planned in four regions of the state, with implementation phased in between July 2014 and January 2015. The state is currently finalizing a Memorandum of Understanding with CMS, working with CMS to develop the Medicare and Medicaid capitation rates for the ICOs and PIHPs, and preparing necessary waiver documents in order to implement the demonstration.

A Request for Proposals (RFP) for the ICOs was released in late July. On November 5th the state released the results of the analysis of submitted proposals and the potential ICO contractors. The table below identifies the successful bidders by region, with their rank ordering on the basis of total score. Approximately 105,000 duals are targeted for this demonstration; the totals by region appear in the table below.

ICO Name	Region 1 All 15 Counties in the Upper Peninsula	Region 4 Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren Counties	Region 7 Wayne County (includes Detroit)	Region 9 Macomb County (an urban county just north of Wayne County)
Estimated Total of Duals Targeted for Demonstration	***9,000***	***21,000***	***58,000***	***17,000***
AmeriHealth Michigan (partnered with BCBS of MI)			Awarded – Rank 4	Awarded – Rank 4
CoventryCares of Michigan		Awarded – Rank 1	Awarded – Rank 3	Awarded – Rank 3
Fidelis SecureCare of Michigan			Awarded – Rank 6	Awarded – Rank 6
Meridian Health Plan of MI		Awarded – Rank 2		
Midwest Health Plan			Awarded – Rank 5	Awarded – Rank 5
Molina Healthcare of Michigan			Awarded – Rank 2	Awarded – Rank 2
UnitedHealthcare Comm. Plan			Awarded – Rank 1	Awarded – Rank 1
Upper Peninsula Health Plan	Awarded			

Three additional plans submitted proposals for the Wayne County Region, but were not ranked among the top six plans chosen tentatively for awards: McLaren Health Plan, Inc., Meridian Health Plan of Michigan and Pro Care Health Plan, Inc. McLaren and Meridian also submitted proposals but were not ranked among the top six plans for the Macomb County Region. There is a 10-day protest period, which could affect the final awards if any of these three bidders are successful in a protest. In addition, each of the tentatively awarded ICOs will need to successfully complete a readiness review.

BCBS of Michigan Medicaid HMO Has Doubled in Two Years. A November 4, 2013 article in Crain's Detroit profiles the significant growth in Blue Cross Blue Shield of Michigan's Medicaid HMO plan, Blue Cross Complete. Over the past two years, Blue Cross Complete, has doubled its membership to 39,000. In particular, the plan is growing in Washtenaw, Livingston, and Wayne County. Executives at the plan expect expansion of Blue Cross Complete into other Michigan counties in 2015. Key to the success in growing its Medicaid managed care business is the $215 million minority investment in AmeriHealth Caritas. Read more.

Health Data Sharing Agreement Forged Among Michigan's Leading HIEs. On October 29, 2013, Michigan's two largest health information exchanges announced an agreement to collaborate in the exchange of electronic medical records. The Michigan Health Connect-Great Lakes Health Information Exchange plan means that most of the clinical information exchanged electronically throughout the state—covering more than 3,000 medical offices and 96 hospitals—will be processed over this new secure network. Read more.

New Hampshire

HMA Roundup

NH Medicaid Expansion House Vote Slated for November 21. On November 1, 2013, Rep. Chris Muns wrote an op-ed commentary about the status of Medicaid expansion in New Hampshire. Following a summer of deliberation, a bipartisan legislative commission recommended that New Hampshire expand Medicaid coverage to all adults 19-64 years of age earning up to $16,000 for one person or $23,000 for a family of three. A special session of the legislature will take up the recommendations, with a joint House-Senate Finance Committee public hearing scheduled for November 12. The recommendations will be sent to the full House and Senate by November 15 and a House vote will take place on November 21. State Rep. Tom Sherman of Rye developed the premium support plan, which was endorsed by the commission, which would add 49,000 adults to the Medicaid rolls, with the proviso that if the federal government reduces its share below the projected 90 percent by 2020, the Medicaid expansion would automatically terminate within six months. Read more.

New York

HMA Roundup—Denise Soffel

Visiting Nurse Service of New York Agrees to Repay $34 Million to NY State. On November 1, 2013, New York State Attorney General Eric Schneiderman announced a tentative agreement with the Visiting Nurse Service of New York (VNSNY), which would result in the repayment to the state of nearly $34 million for improper billings for the use of social adult day care centers. VNSNY, which operates the largest

managed long-term care agency in the state, would be permitted to resume enrolling members in its VNSNY Choice plan. The agreement follows recent layoffs by the organization, in the wake of a New York Times investigation that revealed the enrollment of ineligible seniors in the MLTC plan. Read more.

HANYS Report Focuses on Widely Varying Hospital Report Cards. On November 4, 2013, the Healthcare Association of New York State (HANYS) released a report that evaluates hospital report cards and the widely varying approaches taken by various organizations to rate quality of care. The report discusses that because these comparisons and grades are made in non-standardized inconsistent manners, the tools offered to help consumers choose better providers could actually result in confusing or frustrating them. HANYS compares the approaches of ten national and state-specific hospital quality reports, including those from CMS' Hospital Compare, the Joint Commission Quality Check, the Leapfrog Group, Healthgrades, US News and World Reports, and others. Read more.

Oregon

HMA Roundup

Oregon's Health Exchange Continues to Struggle. Kaiser Health News and NPR explore the troubles experienced by Cover Oregon, the state's health Exchange, which has yet to enroll a single person and has resorted to processing paper applications. When glitches hit the Exchange in early October, executive director Rocky King promised that they would be fixed by mid-October. The snafus with the federal system have constrained tax subsidy eligibility checks, but the state's own system continues to generate inconsistent and incorrect results. Currently, Cover Oregon is sending packets of information via the mail to offer applicants a view of the plan choices and tax credits available to them. Currently, Cover Oregon hopes to have a fully functional site by the end of November. Read more.

Fast-Track Enrollment Waiver Allows OHA to Enroll Medicaid Eligibles without an Application. Last week, Bloomberg published an article highlighting the Oregon Health Authority's (OHA) August 2013 waiver from CMS to offer "fast-track enrollment" for the state's Medicaid program. This approach has allowed OHA to enroll 75 percent of Medicaid-eligible applicants without an application. That is because the state's system already can verify qualifying information from other social programs, such as SNAP or Healthy Kids. President Barack Obama recognized Oregon for its success in enrolling 56,000 qualified Medicaid eligibles (by October 18) despite the lack of online enrollment. Read more.

Pennsylvania

HMA Roundup –Matt Roan

Study Finds 147,000 PA Children Without Health Insurance. The Pennsylvania Partnerships for Children released a study last week that found that more than 147,000 Pennsylvania children lack health insurance, despite the availability of programs through Medicaid and CHIP that would make affordable insurance available. The study's sponsor says that with many parents in PA going without insurance, obtaining insurance for their children may not be a high priority. Complicated applications and re-certifications may also be to blame for the high number of uninsured children, as well as children whose parents are undocumented immigrants who are eligible for coverage programs but who don't apply because of

their parent's immigration status. Governor Corbett has made it a priority to increase CHIP enrollment, and signed a bill recently which eliminates the current waiting period which required that children be without any insurance for six months to be eligible for CHIP. The Commonwealth is also planning enhanced marketing of the CHIP program, something that has not been done in recent years due to state budget constraints. Read more.

Pennsylvania Medical Society Complains of Shortage of Inpatient Psychiatric Beds. Pennsylvania Doctors are claiming that a shortage of inpatient psychiatric beds is causing challenges for emergency departments and they are asking the Commonwealth to do something about it. The Pennsylvania Medical Society passed a resolution last week highlighting the problem and is asking the state to implement a computerized tracking system which would allow emergency departments to locate available psychiatric inpatient beds. With recent closures of psychiatric units in Western Pennsylvania specifically, emergency room physicians say that patients are waiting several hours and in some cases days to be transferred to an inpatient psych unit. The state has said that there is no documented statewide shortage of inpatient psychiatric beds, and that localized shortages should be reported to the Office of Mental Health and Substance Abuse Services. Read more.

PA Lottery Privatization Bid Extended Again, Governor Corbett has announced that the Commonwealth and Camelot Global Services have agreed to extend Camelot's bid on assuming administration of the state's lottery through December 31, 2013. This is the eighth time the bid has been extended as the execution of a contract with Camelot has been held up due to concerns about the legality and constitutionality of the deal. PA Attorney General Kathleen Kane refused to approve the deal which she found violated current state gaming laws, and the PA constitution which provides that the legislature would have to approve such a deal. Democrats including State Treasurer Rob McCord are pressuring the Governor to drop the privatization bid as legal and consulting fees have ballooned with the delayed deals. The PA Lottery revenues support programs for Senior Citizens including Home and Community Based services. Read more.

South Carolina

HMA Roundup

South Carolina Names Five Plans for Duals Demonstration. On November 1, 2013, South Carolina Healthy Connections Prime Medicaid named five health plans to provide coordinated and integrated care for dual eligibles:

- Absolute Total Care, Inc. (Centene)
- Advicare, Corp.
- Molina Healthcare of South Carolina, Inc.
- Select Health of South Carolina, Inc. (AmeriHealth Caritas)
- WellCare Health Plans, Inc.

Humana Health Plan decided not to move forward with its application to participate in South Carolina's demonstration initiative. The readiness review will further evaluate the capacity of each Coordinated and Integrated Care Organization (CICO) to meet all requirements, including network adequacy to cover the full range of beneficiary needs and beneficiary safeguards and protections. Prior to implementation, this unique partnership will be formalized in a three-way contract between each CICO, CMS and the state. Read more.

Virginia

HMA Roundup

McAuliffe Elected Governor and Reiterates Commitment to Expand Medicaid. In a hard fought and tight election, Terry McAuliffe defeated Attorney General Ken Cuccinelli for Governor of Virginia. McAuliffe consistently reiterated his support for Medicaid expansion, but a law passed earlier in 2013 may constrain the momentum to push it through. A special 10-member legislative commission must first consider reforms of the Medicaid program before considering expansion. However, support from the governor's office for Medicaid expansion would mark a significant change from the past four years. Read more.

Washington

HMA Roundup—Doug Porter

Washington Health Care Authority Seeking Public Feedback on Health Care Innovation Plan. On November 4, 2013, the Health Care Authority released a draft State Health Care Innovation Plan (SHCIP) designed to overhaul Washington State's private and public health care system. The five year plan aims at three primary goals: (1) 80 percent of state residents will be healthier, (2) Medicaid clients with physical and behavioral comorbidities will receive high quality care, and (3) annual state purchased healthcare cost growth will be 2 percentage points lower than the national health care cost trend. The state intends to reward value, rather than volumes, which should result in redesigned care delivery systems and community health improvement. New purchasing standards and the coordination of social and health programs are anticipated. Read more.

Wyoming

HMA Roundup

Wyoming Medicaid Expansion Debate to Resume. This week, the Wyoming legislature resumed the debate over Medicaid expansion, considering alternative approaches for expanding healthcare coverage. One option follows the Department of Health's recommendation to construct an alternative version of Medicaid that leverage private insurers, while another would emphasize premium support for health plans available on the health exchange. Last summer, the Health Department recommended "Medicaid Fit" as a hybrid between private health plans and traditional Medicaid in that there would be cost-sharing, but limited benefits. The Arkansas approach is under consideration since provider rates are expected to be superior to the stripped down "Medicaid Fit" proposal. Read more.

National

HMA Roundup

Kaiser Family Foundation releases estimates on Marketplace tax credit eligibles by state. A Kaiser Family Foundation report released November 5, 2013, estimates that about 17 million people who are now uninsured or who buy insurance on their own will be eligible for premium tax credits in 2014. Link to Issue Brief.

2015 Duals Demonstration Medicare application posted by CMS for Idaho, Rhode Island. The Medicare application for plans interested in serving as Medicare-Medicaid plans in a dual eligible financial alignment demonstration for calendar year 2015 was posted on CMS' website. Plans interested in newly participating in 2015 in Idaho and Rhode Island are required to file a Notice of Intent to Apply (NOIA) as part of the application process. 2015 NOIAs are due to CMS on November 14, 2013. CMS states that plans that previously applied for 2014 in Idaho or Rhode Island do not need to complete the 2015 NOIAs, nor do plans that applied in 2014 in any other state with a potential demonstration need to submit a NOIA for that state. Link to Announcement.

CMS' Marilyn Tavenner says marketplace enrollment data to be released week of November 11. Testifying at a Senate Health, Education, Labor, and Pensions committee hearing on November 5, 2013, CMS administrator Marilyn Tavenner committed to the release of enrollment data for the health insurance marketplaces during the week of November 11, 2013. Tavenner also told the committee that more than 700,000 applications had been filed, with roughly half in the federally facilitated marketplaces. Read more.

HHS states concern over third party payments from hospitals, other provider for qualified health plans. Despite ruling last week that qualified health care plans (QHPs) on the state and federal marketplaces are not considered federal health care programs, HHS clarified this week that it strongly discourages third party premium assistance from hospitals and other health care providers. HHS stated in a November 4, 2013, FAQ document that the concern surrounds the potential to "skew the insurance risk pool and create an unlevel field in the marketplaces." HHS further indicated that it "intends to monitor this practice and to take appropriate action, if necessary." Read more.

Early reports show older-than-expected marketplace enrollments. The *National Journal* reported on November 5, 2013, that one state and three companies have indicated their qualified health plan enrollees are older than anticipated. Kentucky's state-run exchange reported that nearly 40 percent of the estimated 4,631 enrollees in private health plans are older than 55, while 24 percent of the remaining enrollees are younger than 34. Michigan-based Priority Health said the average age of new enrollees is 51, up from about 41 for plans offered for the current year. WellPoint said most of its enrollees in Connecticut were between the ages of 55 and 64. Finally, Wisconsin-based Arise Health Plan said more than 50 percent of its 150 enrollees are over age 50.

Industry News

WellCare reports third quarter financial results, names interim CEO. WellCare announced third quarter financial results on Friday, November 1, 2013, reporting that third quarter premium revenue of $2.5 billion grew 38% year over year, driven by a 71% increase in Medicare Advantage segment premium revenue and a 37% increase in Medicaid segment premium revenue. WellCare's Medicaid segment membership increased by 242,000, or 16% year over year, to 1.8 million members as of September 30, 2013. The increase resulted mainly from growth in the Kentucky and Florida programs and the first quarter 2013 acquisitions in Missouri and South Carolina. Meanwhile, WellCare also announced on November 1, 2013, that the company's chairman of the board, David J. Gallitano, had been named interim CEO, replacing Alec Cunningham, while the search for a new CEO is underway.

Humana reports third quarter financial results. Humana reported financial results for the third quarter of 2013 on Wednesday, November 6, 2013. "We are pleased that our operating results continue to show the strength of our base business," said Bruce D. Broussard, President and Chief Executive Officer of Humana. "Additionally, we believe our integrated care delivery model capabilities, like value-based provider contracting, chronic care management and advanced data analytics, provide a successful platform for the emerging opportunities and the challenges of the Medicare payment pressures in the coming years." Humana reported Medicaid membership of 80,000 as of September 30, 2013, up more than 60 percent from the previous year. Read more.

Universal American to acquire Syracuse's Total Care. Syracuse Community Health Center's Total Care Medicaid managed care plan is set to be acquired by Universal American Corp. by the end of November. Total Care enrolls more than 37,000 Medicaid beneficiaries in the Syracuse, New York area. The Total Care health plan has reportedly been posting financial losses since 2008 and has been unable to meet the state's financial reserve requirements, necessitating the sale of the plan. Read more.

Almost Family, Inc. to acquire SunCrest Healthcare. Almost Family, Inc., a leading provider of home health nursing services, today announced that it has signed a definitive agreement to acquire the stock of SunCrest HealthCare. SunCrest, a provider of skilled home health and personal care services generated over $150 million in revenue in 2012 and currently operates over 75 branch locations in nine states. With this acquisition, Almost Family will operate over 240 branches across 14 states and its annual net revenue run rate is expected to approach the $500 million mark. Read more.

Kindred Healthcare announces deal to acquire Senior Home Care. Kindred Healthcare, Inc., a major provider of long-term acute care, announced a deal to acquire Senior Home Care, Inc. on November 4, 2013. Senior Home Care is a home health provider with 47 locations in Florida and Louisiana. Read more.

RFP Calendar

Date	State	Event	Beneficiaries
November 21, 2013	Tennessee	Proposals Due	1,200,000
December 1, 2013	New Hampshire	Implementation	130,000
December 1, 2013	Florida LTC (Region 11)	Implementation	17,257
December 30, 2013	Delaware	RFP Release	200,000
"Early 2014"	North Carolina	RFP Release	TBD
January 1, 2014	Massachusetts CarePlus (ACA)	Implementation	305,000
January 1, 2014	Massachusetts Duals	Implementation	115,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	Wisconsin MLTC (Select Regions)	Implementation	10,000
January 1, 2014	Virginia Duals	Implementation	79,000
January 6, 2014	Hawaii	Contract Awards	292,000
February 1, 2014	Illinois Duals	Implementation	136,000
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,538
March 1, 2014	Florida LTC (Regions 1,3,4)	Implementation	18,971
April 1, 2014	California Duals	Implementation	456,000
April 1, 2014	Ohio Duals	Implementation	115,000
April 1, 2014	Idaho Duals	Implementation	17,700
May 1, 2014	Washington Duals	Implementation	48,500
June 30, 2014	Delaware	Contract awards	200,000
July 1, 2014	South Carolina Duals	Implementation	68,000
July 1, 2014	New York Duals	Implementation	178,000
July 1, 2014	Michigan Duals	Implementation	70,000
September 1, 2014	Vermont Duals	Implementation	22,000
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
October 1, 2014	Florida acute care	Implementation (All Regions)	2,800,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000

Dual Eligible Financial Alignment Demonstration Calendar

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2013 and 2014.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model						
California	Capitated	456,000	X	3/1/2012	4/4/2012	3/27/2013		4/1/2014	Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup
Colorado	MFFS	62,982						4/1/2013	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	2/1/2014	5/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa	MFFS	62,714						TBD	
Idaho	Capitated	22,548	June 2013	TBD	August 2013			TBD	Blue Cross of Idaho
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2014	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	70,000	X	9/10/2013	11/6/2013		30 days prior to passive	7/1/2014	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
Missouri	MFFS‡	6,380					10/1/2012		
Minnesota		93,165	Not pursuing Financial Alignment Model						
New Mexico		40,000	Not pursuing Financial Alignment Model						
New York	Capitated	178,000				8/26/2013	7/1/2014	9/1/2014	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	60 days prior to passive	4/1/2014	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island	Capitated	28,000	X	3/27/2013	August 2013			11/1/2013*	Neighborhood Health Plan of RI
South Carolina	Capitated	68,000	X			10/25/2013		7/1/2014	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	214,402						TBD 2014	
Virginia	Capitated	78,596	X	5/15/2013	6/27/2013	5/21/2013		10/1/2014	Health Keepers; Humana; VA Premier
Vermont	Capitated	22,000	10/1/2013	TBD	TBD			9/1/2014	
Washington	Capitated	48,500	X	5/15/2013	6/6/2013			5/1/2014	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**13 Capitated 6 MFFS**	**1.5M Capitated 485K FFS**	***9***			***8***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

*** Wisconsin is completing a comment period on a draft MOU with CMS. Finalized MOU will determine implementation date.*

‡ Capitated duals integration model for health homes population.

HMA News

HMA's Greg Nersessian and Bloomberg News Talk Exchanges, Medicaid Expansion

On Tuesday, October 15, 2013, HMA's Greg Nersessian sat down with Bloomberg Industries Senior Healthcare Equity Analyst Michael Manns to discuss the implementation of the Affordable Care Act and its impact on public and private health insurance exchanges and Medicaid expansion. A link to their conversation is available here.

"State Innovation Models: Early Experiences and Challenges of an Initiative to Advance Broad Health System Reform"
Commonwealth Fund
Sharon Silow-Carroll, Author
JoAnn Lamphere, Author

Since July 2012, the Centers for Medicare and Medicaid Services has awarded 25 states nearly $300 million to help them plan, design, and test new ways to improve population health and increase the value of health care services they pay for. A new Commonwealth Fund issue brief examines the early experiences of the State Innovation Models (SIM) states, and offers lessons for other states wishing to pursue broad health system reforms while contending with formidable political and budgetary constraints. ***Link to Issue Brief***.

"What the Michigan Health Insurance Marketplace Is and What it Means for You"
Ingham County League of Women Voters
Janet Olszewski, Presenter
November 12, 2013
East Lansing, Michigan

"Michigan Health Insurance Marketplace"
MSU Institute for Health Policy training
Janet Olszewski, Presenter
November 13, 2013
East Lansing, Michigan

"Health Insurance Exchanges"
American Institute of CPAs Healthcare Industry Conference
Barbara Markham Smith, Presenter
November 15, 2013
New Orleans, Louisiana

"Where Payor Meets Provider: Managing in a World of Managed Care"
HCap Conference sponsored by: Lincoln Healthcare Group
Greg Nersessian, Panelist
December 5, 2013
Washington, DC